STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152016	A. BUILDING 00 B. WING	06/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SELECT SPECIALTY HOSPITAL-FORT WAYNE	700 BROADWAY 7TH FL E FORT WAYNE, IN46802

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S0000	The visit was for investigation of two (2) State hospital complaints. Complaint Number: IN 00084347 Substantiated: Deficiencies cited related to the allegations. Complaint Number: IN 00089012 Substantiated: Deficiencies cited related to the allegations. Facility Number: 009856 Dates of Survey: 06/23/11 and 06/27/11 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor QA: claughlin 09/15/11	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S0712	410 IAC 15-1.5-4 (c)(1) (c) An adequate medical record shall be maintained with documentation of service rendered for each individual who is evaluated or treated as follows: (1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information. Based on document review, medical record review and interview, the facility staff failed to document 7 of 11 sets of vital signs and 9 of 11 neurologic checks as required per policy for one patient (#26) following a fall event and failed to document that two patients (#21, #26) were provided baths and oral care as required per policy. Findings: 1. The policy/procedure Fall-Reduction Program (revised 2-09) indicated the following under Post Fall Assessment: Patient will be on Neuro-vascular checks with vital signs: every hour X 4, every 2 hours X 4, every 4 hours X 3 (11 sets in a 24 hour period). 2. On 4-01-11 and 4-02-11, the Post Fall documentation lacked 2 of 4 required every one hour vital signs, lacked 3 of 4 required every one hour neuro-vascular	S0712	Response to tag S721 1.Corrective action for the patients affected by the deficient practice. · 1 current patient had a fall, the assigned nursing personnel were re-educataed to the post fall neuro checks and vital signs requirement. · For this pt, neuro checks and vital signs were initiated and documented in the medical record per policy. · Current patient medical records have been reviewed for documentation of patient care (i.e. baths, oral care.) Staff have been re-educated to the documentation requirements when care is provided. 2.How other patients with the potential to be affected by the deficient practice will be identified and corrective action taken. · The Director of Quality Management (DQM) and/or Chief Nursing Officer (CNO) have re-educated nursing personnel to the post fall neuro check and vital signs requirements per policy and ADL and oral care documentation requirements. · The DQM and/or	10/31/2011

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	checks, lacked 4 of 4 required every two hour vital signs and neuro-vascular checks, lacked 1 of 3 required every four hour vital signs, and lacked 2 of 3 required every four hour neuro-vascular checks for patient #26. 3. During an interview on 6-30-11 at 0710 hours, staff #S8 confirmed that only 4 of 11 sets of vital signs and 2 of 11 sets of neuro-vascular checks were documented during the 24 hour post fall period for patient #26. 4. The policy/procedure Guidelines and Protocols (revised 10/08) indicated the following under the category Hygiene; patient bathed daily, bed linen changed daily and prn, oral care every AM before breakfast and every HS (hour of sleep), and oral care every 4 hours for NPO, tube feedings, and ventilated patients. 5. The 24 hour Patient Record for patient #21 lacked documentation that a bath was provided on 12-30-10 and 1-02-11 or that oral care was provided on 12-30-10, 12-31-10 and 1-02-11 between 0700 and 1900 hours. 6. The 24 hour Patient Record for patient #26 lacked documentation that a bath was provided on 4-01-11 or 4-03-11 or that oral care was provided between 04-01-11		designee will monitor compliance with documentation of post fall neuro checks and falls to ensure compliance. · The DQM and/or designee will monitor compliance with documentation of ADLs and oral care compliance per policy. 3. Measures put into place or system changes initiated to ensure deficient practice does not recur. • Frequent vital/Neuro forms will be Utilized with each fall to monitor Neuro status to include Neuro checks every hour x 4, every 2 hours x 4 and every 4 hours x 3 per the policy. • Staff will be re-educated to policy F02-G, Fall Reductions and the Frequent Vital/Neuro forms. • CNA staff have been re-educated to the proper documentation of ADL care on 24 hour flow sheets. 4. How the corrective action will be monitored to ensure deficient practice will not recur. Who will be responsible? • DQM and/or designee will audit 100% of all falls that occur for Compliance with Fall Reduction Policy. • DQM and/or designee will audit 30 random records per month for compliance with documentation of ADLs and oral care for 3 months and randomly thereafter to maintain compliance. Audit results will be reviewed in the monthly QAPI committee meetings and reported quarterly to OIC/MEC/GB for additional improvement actions as needed. 5. Responsible: · DQM and CNO Date of Compliance: 10/31/11	

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	at 1600 hours until 04-02-11 at 2300 hours or 04-03-11until 04-04-11.			
S0948	410 IAC 15-1.5-7 (c)(5) (c) Drugs and biologicals shall be prepared for administration and administered as follows: (5) In accordance with currently acceptable standards of practice. Based on document review and interview, the facility failed to ensure medications were administered and documented per policy for 2 of 7 patients. Findings: 1. The policy/procedure Medication Administration (revised 7-01-10) indicated the following; All scheduled medications on the MAR must have corresponding charting. A given medication dose will be designated by placing a slash (/) through the time followed by the administrator's initials. 2. Review of the MAR dated 12-27-10 and 12-28-10 for patient #21 indicated 10 medications (Arixtra, Aspirin, Bisacodyl, Famotidine, Ferrous Sulfate, Fibercon, Furosemide, Klor-Con, Spiriva, and Symbicort) ordered and not designated as given with a slash (/) through the time. 3. Review of the MAR dated 4-01-11 for patient #26 lacked pages 5 and 6 including prn medications. Staff #A1 was requested to provide missing documentation and none was provided prior to exit.	S0948	Response to tag S948 1.Corrective action for the patients affected by the deficient practice. · No patients were negatively affected by this practice. 2.How other patients with the potential to be affected by the deficient practice will be identified and corrective action taken. · Current patients MARs have been reviewed for proper Medication Administration documentation. 3. Measures put into place or system changes initiated to ensure deficient practice does not recur. · Registered Nurse's (RNs) and Respiratory Therapist (RTs) will be re-educated on policy M01-N, Medication Administration by the CNO. 4. How the corrective action will be monitored to ensure deficient practice will not recur. Who will be responsible? · After re-education of the	10/31/2011

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	4. Review of the MAR dated 4-03-11 for patient #26 indicated 3 medications (Famotidine, Gabapentin, Hydralazine) ordered and not designated as given with a slash (/) through the time. 5. Review of the MAR dated 4-04-11 for patient #26 indicated 2 medications (Alprazolam, Hydralazine) ordered and not designated as given with a slash (/) through the time.		RNs and RTs are complete, the DQM and/or CNO will monitor 25 random MARs per week x 30 days and randomly thereafter as needed, for adherence to policy M01-N, specific to slashing medication time and initialing. Audit results will be reviewed in the monthly QAPI committee meetings and reported quarterly to OIC/MEC/GB for additional improvement actions as needed. 5. Responsible: · DQM or CNO Date of Compliance: 10/31/11	
S1038	410 IAC 15-1.5-7 (d)(3)(4)(5)(6) (d) Written policies and procedures shall be developed and implemented that include the following: (3) Review the use of medications with the standards developed by the medical staff, which include stop orders for scheduled drugs and biologicals not specifically prescribed as to time or number of doses. (4) Allow for adequate drug therapy monitoring procedures to exist. (5) Minimize medication errors and document, monitor, evaluate, and report adverse drug reactions and medication errors. (6) Provide for the maintenance of drug and poison information materials. Based upon document review and	S1038	Response to tag S1038 1.Corrective action for the	10/31/2011

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	interview, the facility failed to identify and report a medication error for 1 of 7 patients (pt #21) which resulted in 6 missed doses before the medication was given to the patient. Findings: 1. On 12-24-2010, a pharmacy automatic stop/reorder document indicated Nystatin 100,000 unit/ml suspension 5 ml. by mouth twice daily (stop date 12-25-10 at 21:00 hours) was reordered by the physician for patient #21. 2. On 12-26-10 until 12-29-10, the Medication Administration Records (MAR) lacked documentation of Nystatin administration for patient #21. 3. On 12-29-10, physician progress notes indicated oral thrush and Nystatin 100,000 unit/ml suspension 5 ml by mouth twice daily was ordered again for patient #21. 4. On 6-27-11 at 1200, staff #A1 confirmed that the pharmacy had failed to follow the physician order of 12-24-10 to reorder Nystatin on 12-25-10 for patient #21. 5. On 6-28-11 at 1145, staff #A4		patients affected by the deficient practice. · The patient affected by this practice received the medication. 2.How other patients with the potential to be affected by the deficient practice will be identified and corrective action taken. · Current patients have been reviewed to determine current orders are being followed. There were no deficiencies found with current patients. 3. Measures put into place or system changes initiated to ensure deficient practice does not recur. · Clinical Staff will be re-educated by the DQM and/or CNO to Policy R03A Incident Reporting and policy M03-P Medication Error Policy. 4. How the corrective action will be monitored to ensure deficient practice will not recur. Who will be responsible? · The DQM will review 5 random charts weekly. Reviewing orders against MAR for a 7 day period on each patient to assure that Transcription/Omission errors did not occur. · DQM will report any errors to the CNO for follow up and record in the Incident Reporting System. · Audit results will be reviewed in the monthly QAPI committee meetings and reported	

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	confirmed that an incident report of the Nystatin medication error for patient #21 had not been completed by staff at the facility.		quarterly to OIC/MEC/GB for additional improvement actions as needed. 5. Responsible: · DQM & CNO Date of Compliance: 10/31/11	